Bridging the Gap:
Male Service Recommendations

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Disclosures

- Nothing to disclose
  - No financial interests or relationships with manufacturers of commercial products, suppliers of commercial services or commercial supporters
  - I will not discuss unlabeled use of products or products under investigational use
  - No commercial support provided for this activity

Objectives

1. Describe males' sexual & reproductive health (SRH) needs
2. Discuss recommended SRH services to deliver to reproductive-aged males
3. Understand the process that was used in the development of these recommendations

www.cdc.gov/mmwr/pdf/rr/rr6304.pdf

www.maletrainingcenter.org

Background

Males have substantial SRH needs related to…

- Puberty & development
- Sexual identity formation
- Achieving healthy relationships
- Sexual behavior & related outcomes
  - Preventing pregnancy (e.g., male & female methods)
  - Planning for pregnancy (e.g., preconception care & infertility concerns)
  - STDs & HIV
  - Reproductive-related cancers
  - Problems with sexual function
  - Comorbid behaviors (e.g., alcohol, drug use)
  - Comorbid conditions (e.g., depression, medications)

Marcell & Committee on Adolescence. Pediatrics. 2011, 128(6): e1658-76.

Why is it important to engage males in SRH?

1. Meet SRH needs in their own right
2. Improve health outcomes of partners
3. Involve them as critical partners in family planning to ensure pregnancies are planned & wanted
4. Improve capacity for parenting, fathering & child health outcomes
5. Use SRH as clinical hook to address other health needs
6. "Providers" (e.g., parents, teachers, healthcare) lack sufficient knowledge & skills on addressing males' SRH
7. Males are not socialized around health care & SRH care

Marcell et al. Pediatrics. 2011.
Frey et al. AJOG. 2008.

Few males receive SRH care
Disparities by gender

According to provider & patient reports

	Female	Male
Assess for sexual health	45%	**15%**
Counsel on STIs, HIV, pregnancy	61%	**34%**
Assess/counsel on contraception	33%	**5%**
Counsel on condoms	18%	**7%**

Burstein GR, et al. Pediatrics. 2003, 111:996-1001
Lafferty WE, et al. AJPH. 2002; 92, 1779-83
Chandra et al. NSFG. 2006-10.

Do young men want to talk about SRH care?

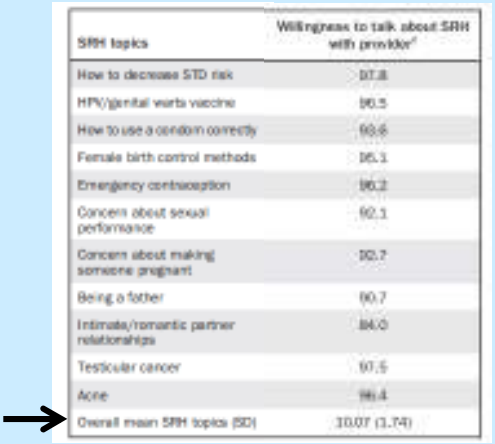
SRH Topics
1. Decreasing STI risk
2. HPV/genital warts vaccine
3. Using condoms correctly
4. Female birth control methods
5. Emergency contraception
6. Sexual function
7. Making someone pregnant
8. Fatherhood
9. Intimate/romantic partner relationships
10. Testicular cancer
11. Acne

- Sample of young African American & Latino male clinic patients in 2 urban cities

Same, Bell, Rosenthal, Marcell. Am J Prev Med. 2014.

Yes: Majority of males, regardless of age, want to talk with their healthcare provider about SRH

- 84-98% report being willing to talk about **all** SRH topics
- 45-86% report wanting doctor to bring it up 10 of 11 topics



SRH topics	Willingness to talk about SRH with provider*
How to decrease STD risk	97.8
HPV/genital warts vaccine	96.5
How to use a condom correctly	93.6
Female birth control methods	95.1
Emergency contraception	96.2
Concern about sexual performance	92.1
Concern about making someone pregnant	92.7
Being a father	90.7
Intimate/romantic partner relationships	84.0
Testicular cancer	97.5
Acne	98.4
Overall mean SRH topics (SD)	10.07 (1.74)

Same, Bell, Rosenthal, Marcell. Am J Prev Med. 2014.

What accounts for discrepancy in young men's SRH care delivery?

Challenges in SRH care delivery to males

1. Until now, no one national organization has outlined clinical standards of SRH care to deliver to reproductive-aged males
2. Lack of research with males in clinical settings to inform clinical guidance
3. Existing guidelines are single-topic focused & lack a comprehensive SRH framework

What constitutes SRH care for males?

QFP & MTC guidance on men's SRH care

1. CDC & DHHS Office of Population Affairs **Providing Quality Family Planning Services** (***QFP***), 2014
2. Male Training Center (MTC) **Preventive Male SRH Care: Recommendations for Clinical Practice**, 2014

www.cdc.gov/mmwr/pdf/rr/rr6304.pdf

www.maletrainingcenter.org

Guidance development

- **Used an evidence-informed approach**
  - Examined professional organizations for recommendations & relied on evidence-based recommendations whenever possible
  - Conducted systematic reviews for gap areas (e.g., topics without evidence)
- MTC convened **Men's Health Technical Panel** to provide feedback (1 of 6 technical panels convened)
- Recommendations were then drafted & presented to an Expert Work Group (EWG) presiding over entire process
- CDC & OPA considered EWG feedback to develop final set of core recommendations for *QFP*

QFP decisions

For men's health guidance components

1. Used WHO SRH definitions as starting point to consider SRH care to deliver to men
2. *Identified core services: Contraception, Basic infertility, Preconception health, & STD services*
3. *Identified assessing client's reproductive life plan & comprehensive sexual history as cornerstones to determine relevant services to deliver*
4. *Used hierarchical approach for providing each service given inconsistencies between organizations*
   #1 CDC (STD treatment, HIV testing, preconception care)
   #2 USPSTF (United States Preventive Services Task Force)
   #3 Other organizations (AAP's Bright Futures for adolescents)
5. *Identified other related preventive health services for men linked closely with family planning services*
6. *Made recommendations against providing services shown to be ineffective or when potential harm outweighs benefit*
7. *Integrated recommendations for men's health throughout QFP rather than just separate section focused on men, or treated as "special population"*

SRH definition & framework*

"A state of physical, mental & social well-being & not merely absence of disease, dysfunction or infirmity in all matters relating to reproductive system, its functions & its processes"

Cairo UN International Conference on Population & Development. 1994.
WHO. Defining sexual health. Geneva, Switzerland. 2002.
CDC. A public health approach for advancing sexual health in U.S. Atlanta, GA. 2011.

Identified SRH care goals for males

Prevent
- STIs & HIV
- Unintended pregnancy (e.g., family planning)
- Reproductive health cancers

Promote
- Sexual health & development
- Reproductive life plan (e.g., timing & spacing of children)
- Preconception health
- Healthy relationships & behavior

Reduce
- Sexual problems & infertility

Increase
- Lifespan/survival & quality of life
- Access to clinical services & client satisfaction

QFP decisions cont.

For men's health components of guidance

1. *Used WHO SRH definitions as starting point to consider SRH care to deliver to men*
2. Identified **core services**: Contraception, Basic infertility, Preconception health, & STD services
3. Identified assessing **client's reproductive life plan** & **comprehensive sexual history** as cornerstones to determine relevant services to deliver
4. Used **hierarchical approach** for providing each service given inconsistencies between organizations
   - #1 **CDC** (STD treatment, HIV testing, preconception care)
   - #2 **USPSTF** (United States Preventive Services Task Force)
   - #3 Other organizations (AAP's **Bright Futures** for adolescents)
5. **Identified related preventive health services** for men linked closely with family planning services
6. **Made recommendations against providing services** shown to be ineffective or when potential harm outweighs benefit
7. **Integrated recommendations** for men's health **throughout** *QFP* rather than just separate section focused on men, or treated as "special population"

MTC Men's Health Technical Panel

- MTC's effort focused on men's SRH more broadly, & not just on family planning
- **MTC document**
  - Summarizes *QFP* clinical preventive service recommendations,
  - **Highlights further deliberations** by Men's Health Technical Panel for services to include, &
  - Provides tools & resources for providers

Recommended clinical preventive SRH services for males

Recommended services

History		
Reproductive life plan [1]	√	QFP
Sexual health assessment [4]	√	QFP
Problems with sexual function	√	MTC
Intimate partner & sexual violence	√	MTC
Alcohol & other drug use	√	QFP
Tobacco use	√	QFP
Immunizations	√	QFP
Depression	√	QFP
Physical Exam		
Height, weight & BMI	√	QFP
Blood pressure	√	QFP
External genital/perianal exam	√ [5]	QFP
Laboratory Tests		
Chlamydia	√ [6]	QFP
Gonorrhea	√ [7]	QFP
Syphilis	√ [8]	QFP
HIV/AIDS	√ [9]	QFP
Hepatitis C	√ [10]	QFP
Diabetes	√ [11]	QFP

Key SRH Counseling		
Condoms with demonstration/practice	√	MTC
STD/HIV	√	QFP
Pregnancy prevention including male & female methods & EC	√	QFP
Preconception health	√	QFP
Sexuality/relationships	√ [12] / √ [13]	MTC
Sexual dysfunction	√	MTC
Infertility	√	QFP

Screening services no longer recommended

History	Teaching testicular self-exam (for cancer screen)	✗
Exam	Testicular exam (for cancer screen)	✗
	Hernia	✗
Labs	Gonorrhea (low risk)	✗
	Hepatitis B (low risk) *	✗
	Hepatitis C (not born '45-'65)	✗
	Herpes simplex	✗
	Syphilis (not at increased risk)	✗
	PSA for prostate cancer	✗
	Urinalysis	✗
	Hemoglobin / hematocrit	✗

No recommendation:
Evidence still being accumulated

Labs	Trichomonas	?
	Human papillomavirus	?
	Anal cytology	?

Details about each service

History components
Cornerstone Component 1

Content — **Reproductive life plan**

Questions

- Assess among individuals capable of having a child whether they have a reproductive life plan
  - Have you ever made someone pregnant / are you currently a father?
  - Do you want to have (more) children?
  - How many (more) children would you like to have & when?

Who/When

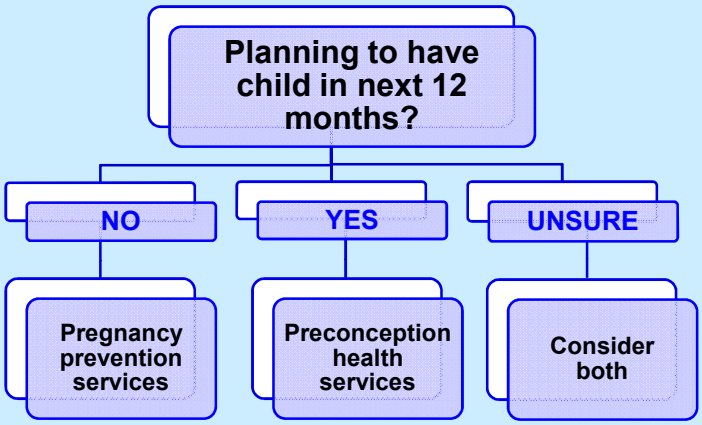
- All ages / Each encounter

Source

- CDC Preconception care

History: Reproductive life plan

- **Prioritize appropriate services to deliver**



History:
What is goal of preconception health?

- To optimize health before conception & reduce adverse maternal & infant outcomes (e.g., preterm birth, low birth weight, infant mortality)
- More recently inclusion of males
  - Attuned to "anticipatory fatherhood" & minimize gender disparities
- Specific benefits for men
  - Improve genetic & biologic contributions to a pregnancy
  - Be involved in planning & spacing of pregnancies
  - Improve overall health
- **Additional history:** Past medical/surgical history impairing reproductive health (e.g., genetic defects, reproductive failure), conditions reducing sperm quality (e.g., obesity, DM, varicocele & STDs), occupational/environmental exposures

Frey et al. The clinical content of preconception care: preconception care for men. AJOG. 2008; 199:S389-395.
Waggoner. Motherhood preconceived: the emergence of the Preconception Health and Health Care Initiative. J Health Polit Policy Law. 2013;38(2):345-71.

History components
Cornerstone Component 2

Content	**Sexual health assessment**
Questions	• Use 5 P's approach to conduct sexual health assessment
Who/When	• All ages / Each encounter
Source	• CDC

History: Sexual health assessment

5 P's approach

Practices	Assess for types of sexual behavior patient engages in (e.g., vaginal, anal, &/or oral sex)
Partners	Ask questions to determine number, sex, & concurrency of patient's sex partners. May need to define term "partner" to patient or use other, relevant term
Pregnancy prevention	Discuss current & future partner contraceptive options
Protection from STDs	Ask about condom use, with whom they do or do not use condoms, & situations that make it harder or easier to use condoms
Past STD history	Ask about STD history, including whether partners ever had STD

History components

Content: Problems with sexual function

Questions:
- Ask do you have any difficulty with intercourse/problems when having sex?
- **Rationale:** Identify underlying cardiovascular disease among men presenting with sexual dysfunction symptoms

Who/When:
- All ages but especially above 25 / Each encounter

Source:
- Princeton Consensus Conference
- Male Training Center

History components

Content: Intimate partner & sexual violence

Questions:
- Assess for history of abuse including intimate partner & sexual violence experience & perpetration along with a history of childhood/family violence exposure
- **Rationale:** Abuse may be bidirectional within relationship context
- Providers **must** comply with state mandatory reporting guidelines regarding abuse

Who/When:
- All ages / Each encounter

Source:
- Bright Futures
- Male Training Center

Mandatory reporting
Maryland law

- **When is it considered a crime if minor has consensual vaginal intercourse with older (or younger) partner?**

AGE OF PATIENT (VICTIM'S AGE)	AGE OF PARTNER (DEFENDANT'S AGE)									
	12	13	14	15	16	17	18	19	20	21+
12	No	No	No	No	2nd Degree Rape	2nd Degree Rape	2nd Degree Rape	2nd Degree Rape	2nd Degree Rape	2nd Degree Rape
13	No	No	No	No	No	2nd Degree Rape	2nd Degree Rape	2nd Degree Rape	2nd Degree Rape	2nd Degree Rape
14	No	No	No	No	No	No	4th Degree Sexual Offense	4th Degree Sexual Offense	4th Degree Sexual Offense	3rd Degree Sexual Offense
15	No	No	No	No	No	No	No	4th Degree Sexual Offense	4th Degree Sexual Offense	3rd Degree Sexual Offense
16	No	No	No	No	No	No	No	No	No	No
17	No	No	No	No	No	No	No	No	No	No
18+	No	No	No	No	No	No	No	No	No	No

From Walker v. State, 363 Md. 253, 264 (2001)

- **Providers are mandated to report all physical abuse & sexual abuse only when perpetrator is family member or other caretaker****

** Has had permanent or temporary care, custody or responsibility for supervision of child, or by any household or family member

http://www.jhsph.edu/research/centers-and-institutes/center-for-adolescent-health/publications_resources/

History components

Content: Alcohol & other drug use

Questions:
- Assess for alcohol misuse in adults & adolescents & for other drug use
- **Rationale:** alcohol & other drug use before & during sex may lead to lack of condom use, STD/HIV acquisition, &/or unintended pregnancy; problems with sexual function

Who/When:
- All ages / Each encounter

Source:
- CDC Preconception Care
- USPSTF & Bright Futures

History components

Content	**Tobacco use**
Questions	• Assess about smoking & use of other tobacco products
Who/When	• All ages / Each encounter
Source	• CDC Preconception Care • USPSTF & Bright Futures

History components

Content	**Immunizations**

Questions	• Assess SRH-related vaccine receipt & offer (as needed)
	  • Human papillomavirus (HPV)
	  • Hepatitis B (HBV)
	  • Hepatitis A (HAV)

Who/When	• Refer to next slides / At least annually
Source	• CDC ACIP

History: HPV

- **Recommended for all males aged 11-26 (minimum age 9)**
  - Start: age 11-12 years
  - Catch-up: ages 13-21 who have not been vaccinated previously or completed 3-dose series through age 21
- Males aged 22-26 years ***may*** be vaccinated (permissive recommendation for this age group)
  - Routine vaccination is recommended among at-risk males, including MSM & immune-compromised males, through age 26 years

History: HBV

- **Recommended among males aged <19 years & all adults who are at-risk**
- **At-risk defined**
  - Sexual exposure including MSM
  - Injection-drug users
  - Household contacts of persons with chronic HBV infection
  - Developmentally disabled persons in long-term care facilities
  - Persons at risk for occupational exposure to HBV
  - Hemodialysis patients
  - Persons with chronic liver disease
  - Travelers to HBV-endemic regions
  - HIV-positive
  - Persons who request vaccination

History: HAV

- **Recommended for persons at-risk**
- **At-risk defined**
  - Sexual exposure including MSM
  - MSM
  - Users of injection & non-injection drugs
  - Persons who have occupational risk for infection
  - Persons with clotting-factor disorders
  - Persons with chronic liver disease
  - During outbreaks
  - Persons traveling to or working in countries that have high or intermediate endemicity of infection

History components

Content	**Depression**
Questions	• Assess for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment & follow up • **Rationale:** Increased depression risk seen among those struggling with sexual identity issues, stress during coming-out process, relationship break-up, or self-esteem
Who/When	• All ages / Each encounter
Source	• CDC Preconception Care • USPSTF & Bright Futures

History: Suicide

- **Assess for suicide risk among persons reporting symptoms of depression & other risk factors**

  Risk factors defined
  - Mania or hypomania, or mixed states especially when complicated by comorbid substance abuse, irritability, agitation, or psychosis
  - Previous suicide attempts
  - Family history of suicide
  - Friends who have committed suicide
  - Access to gun
  - History of mood/conduct or psychotic disorders
  - Impulsive behaviors or attention deficit/hyperactivity disorder
  - Concerns about sexual identity
  - History of physical/sexual abuse

Physical exam components

Content	**Height, weight & BMI**
Exam	• Assess for obesity including measure weight, height, & calculation of body mass index (BMI) • Obese persons should be offered or referred to intensive counseling & multicomponent behavioral interventions
Who/When	• All ages / At least annually
Source	• CDC Preconception Care • USPSTF & Bright Futures

Physical exam components

Content: Blood pressure

Exam:
- Measure among adults every 2 years if normal (blood pressure <120/80) & every year if client has pre-hypertension (blood pressure 120-139/80-89)
- **Measure in adolescents annually**

Who/When:
- All ages / At least annually (as per above)

Source:
- CDC Preconception Care
- USPSTF & Bright Futures

Physical exam components

Content: External genital / perianal

Exam:
- Document normal growth & development (e.g., testosterone effect [Sexual Maturity Rating (SMR) for hair & genitals]) & other common genital findings (e.g., hydrocele, varicocele, STD signs)
- Inspect skin & hair, palpate inguinal nodes, scrotal contents & penis, & inspect perinanal region (as indicated, e.g., history of receptive anal sex)

Who/When:
- Adolescents / At least annually

Source:
- Bright Futures & Society for Adolescent Health & Medicine

Laboratory test components

Content: Chlamydia

Lab:
- Urine-based nucleic-acid amplification tests (NAATs) is preferred approach
- Rescreen males with Chlamydia for reinfection at 3 months (via urine or rectal swab; not pharyngeal)

Who/When:
- At-risk <25 / At least annually

Source:
- QFP: CDC

At-risk defined
- MSM (men who have sex with men)
- Specific settings
  - Adolescent clinics
  - Correctional facilities
  - STD clinics
  - National Job Training Program
  - In military <30 y/o with any sexual experience
  - Entering jails <30 y/o or juvenile facilities
  - **High prevalence communities**

Laboratory test components

Content: Gonorrhea

Lab:
- Urine-based nucleic-acid amplification tests (NAATs) is preferred approach

Who/When:
- At-risk including MSM / At least annually

Source:
- CDC STD Treatment Guidelines

Laboratory: Gonorrhea

- Rescreen males with gonorrhea for reinfection at 3 months
- More frequent STD screening (i.e., at 3–6-month intervals) indicated for MSM who have multiple or anonymous partners
- For MSM who've had sex in last year, screen at least annually:
  - Using urine NAAT, for men reporting insertive sex
  - Using rectal swab NAAT, for men reporting receptive anal sex
  - Using pharyngeal swab NAAT, for men reporting receptive oral sex

Laboratory test components

Content	**Syphilis**
Lab	• RPR / VDRL
Who/When	• At-risk / At least annually
Source	• QFP: CDC

At-risk defined
- MSM
- Men engaging in high-risk sexual behavior
- Commercial sex workers
- Persons who exchange sex for drugs
- Persons in adult correctional facilities
- High prevalence communities
- Young MSM with risky behaviors may require more frequent screening (3-6-month intervals) (e.g., multiple or anonymous sex partners)

Laboratory test components

Content: HIV / AIDS

Lab
- Rapid test (3rd gen)
- Serology (3rd or 4th gen)
- Provide opt-out screening (notify test is performed as part of general medical consent unless patient declines)

Who/When
- All 13-64 initial; Follow-up at-risk

Source
- QFP: CDC

At-risk defined
- MSM
- Injection drug users & sex partners
- Persons exchanging sex for money/drugs
- Sex partners of HIV-infected persons
- MSM or heterosexual persons who themselves or whose sex partners have >1 sex partner since most recent HIV test

Laboratory test components

Content: Hepatitis C

Lab
- Serology

Who/When
- Born 1945-65 / At least annually

Source
- CDC STD Treatment Guidelines

Laboratory: Hepatitis C

- Anti-HCV test recommended for routine screening of persons at-risk for infection or based on a recognized exposure (e.g., MSM, injecting drug user, high risk sexual behavior)
- Persons identified with HCV infection should receive brief alcohol use screen & intervention as clinically indicated, followed by referral for HCV care

Laboratory:
Positive tests or testing for diagnostic purposes

Refer to

- **CDC STD Treatment Guidelines 2010**
  (2015 guidelines forthcoming)
  PDF: cdc.gov/std/treatment/2010/default.htm
  iPad, iPhone & iPod Touch: cdc.gov/std/2010-ebook.htm
- **CDC HIV Prevention & Treatment Guidelines 2013**
  PDF: cdc.gov/hiv/living/treatment/guidelines.htm

Laboratory test components

Content	**Diabetes**
Lab	• Screen among asymptomatic adults with sustained blood pressure (either treated or untreated) >135/80 mm Hg
Who/When	• At-risk adults (see above) / At least annually
Source	• USPSTF & CDC Preconception care

Key SRH counseling components

Content	**Condoms with demonstration / practice**
Counsel	• Offer male patients to view & practice condom demonstration
Who/When	• All ages especially adolescents / Based on need
Source	• Male Training Center

Counseling: Condoms

Teach steps for putting on & removing a condom

1. Pinch tip of condom
2. Roll condom down to base while leaving tip pinched
3. After ejaculation occurs, hold condom at its base before withdrawing
4. Hold condom at its tip & base & remove it from penis
5. Throw it away

Other teachable points

1. Check expiration date
2. Check package for air bubbles
3. Do not open package with teeth or sharp object
4. Use only water-based lubricants with latex condoms,
5. Do not use spermicides (e.g., nonoxynol-9) since can break down latex & increase susceptibility to STDs including HIV

Teachable points for partners to discuss for optimal use

1. Contraception methods in advance including who will purchase condoms
2. Latex allergies
3. Type of condom to use (ie, latex, polyurethane, lambskin)
4. Condom characteristics (e.g., size, ribbed, lubricated, contain spermicides, etc.)
5. Try different condoms to find one that fits & feels best

Counseling: Condoms

Bottom line: Condoms come in different sizes & varying thickness

→→ **Make wide variety of condoms, lubrication & other barrier methods (dental dams) available at your clinic**

Key SRH counseling components

Content	**STD / HIV**
Counsel	• Provide high intensity behavioral counseling about STD prevention • Provide access to HIV pre-exposure prophylaxis (PREP) & post-exposure prophylaxis (PEP) as appropriate
Who/When	• All sexually active adolescents & at-risk adults / At least annually
Source	• USPSTF / CDC

Counseling: STD/HIV

Example

- 2 separate 20-minute clinical sessions 1 week apart
  - **1st session** Patients assessed for personal risk, barriers to risk reduction, & identification of a small risk-reduction step within 1 week
  - **2nd session** Review prior week's behavioral change successes & barriers, provide support for changes made, identify barriers & facilitators to change, & develop a long-term plan for risk-reduction

Key SRH counseling components

Content	**Pregnancy prevention**
Counsel	• Counsel about **male methods** (e.g., vasectomy, condoms, withdrawal) & **female methods** (e.g., long-acting reversible methods, combination methods & emergency contraception (EC)) • Provide EC in advance as allowed by state law
Who/When	• All ages / Based on need
Source	• Bright Futures

Counseling: Pregnancy prevention

- Work with client to establish patient-centered plan for using contraceptive method(s) of choice
  1. Address "4 Cs"
     - **C**hoice
     - **C**orrect use
     - **C**onsistent use
     - **C**ontinued use & switching
  2. Discuss effectiveness
  3. Ensure understanding of side effects (use "teach back" approach)
  4. Involve partner in plan
  5. Plan for follow-up
- Promote dual protection for clients at-risk for STDs (i.e., effective method to prevent pregnancy plus condom to prevent infection)

Key SRH counseling components

Content	**Sexuality & relationships**
Counsel	• **Sexuality:** Provide support to males who may be dealing with issues of sexuality that can affect their psychosocial & physical health via individual support, support for families, &/or referral to local resources as appropriate • **Relationships:** Provide support to adolescents in how to have healthy relationships
Who/When	• All ages especially adolescents / Based on need
Source	• Male Training Center

Key SRH counseling components

Content	**Problems with sexual function**
Counsel	• Provide support based on sexual problem etiology • These are common medical conditions that may need to be managed from multidisciplinary perspective
Who/When	• Based on need
Source	• American Urological Association • Male Training Center

Counseling: Sexual function

- For specific evaluation, treatment guidelines, & algorithms refer to:
  - Montorsi F, Adaikan G, Becher E, et al. Summary of the recommendations on sexual dysfunctions in men. J Sex Med 2010 Nov;7(11):3572-3588.
  - Montorsi F, Basson R, Adaikan G, et al., eds. Sexual medicine: Sexual dysfunctions in men and women. Paris, France: Editions 21; Co-Sponsored by International Consultation on Urological Diseases (ICUD) & International Society for Sexual Medicine (ISSM); http://www.icud.info, 2010.
- Note: Erectile dysfunction (ED) may be an early sign of systemic cardiovascular disease (esp ≥25 years old)
  - Prevention opportunity, especially in high-risk & underserved minority populations

Key SRH counseling components

Content	**Preconception health**
Counsel	• Counsel about preconception care services for patient & their partner
Who/When	• All ages / Based on need
Source	• CDC Preconception care

Key SRH counseling components

Content	**Infertility**
Counsel	• Provide basic infertility services, which includes initial infertility history & physical exam (as previously described), & appropriate education & referrals as needed
Who/When	• Based on need
Source	• American Urological Association

Bringing it together

Scenario 1

15-year-old male is at your clinic for a routine physical examination.

He has a history of asthma & ADHD. He has no concerns.

He states he does not intend to have children in the next 12 months, but that he has a sexual partner.

What clinical preventive SRH services do you provide him?

QFP/MTC checklist for male services

Organizing/bundling by content area

Component	Service	Content area: Contraceptive	Preconception health	STD	Basic infertility	Related preventive health
History	Reproductive life plan	Screen	Screen	Screen	Screen	
	Sexual health assessment	Screen	Screen	Screen	Screen	
	Problems with sexual function				Screen	Screen
	Intimate partner & sexual violence					Screen
	Alcohol & other drug use		Screen			Screen
	Tobacco use		Screen			Screen
	Immunizations		Screen			Screen
	Depression		Screen			Screen
Exam	Height, weight, BMI		Screen			Screen
	Blood pressure		Screen			Screen
	Genital exam			Screen	Screen	Screen
Lab	Chlamydia			Screen		
	Gonorrhea			Screen		
	Syphilis			Screen		
	HIV/AIDS			Screen		
	Hepatitis C			Screen		
	Diabetes		Screen			
Counseling	Condoms with practice	X		X		
	STD/HIV			X		
	Pregnancy prevention	X				
	Preconception health		X			
	Sexuality & relationships					X
	Sexual dysfunction					X
	Infertility				X	

Scenario 1 cont.

What if this same 15-year-old came for an acute visit?

"He states he does not intend to have children in the next 12 months, but that he has a sexual partner."

What clinical preventive SRH services do you provide him?

- Conduct same-day STD screening
- Make follow-up appointment to address his sexual health

Scenario 2

25-year-old male presents to your clinic for a work physical.

He shares he & his partner are planning to start a family in the next year.

What clinical preventive SRH services do you provide him?

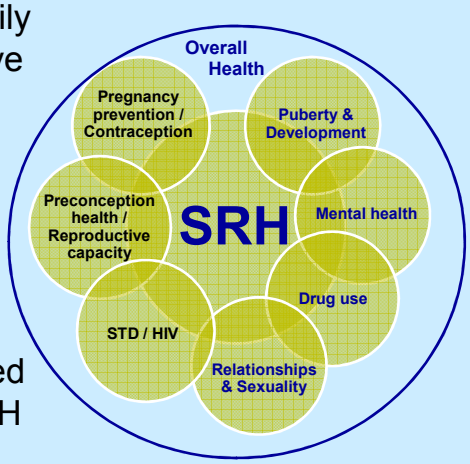
QFP/MTC checklist for male services

Organizing/bundling by content area

Component	Service (Content area)	Contraceptive	Preconception health	STD	Basic infertility	Related preventive health
History	Reproductive life plan	Screen	Screen	Screen	Screen	
	Sexual health assessment	Screen	Screen	Screen	Screen	
	Problems with sexual function				Screen	Screen
	Intimate partner & sexual violence					Screen
	Alcohol & other drug use		Screen			Screen
	Tobacco use		Screen			Screen
	Immunizations		Screen			Screen
	Depression		Screen			Screen
Exam	Height, weight, BMI		Screen			Screen
	Blood pressure		Screen			Screen
	Genital exam			Screen	Screen	Screen
Lab	Chlamydia			Screen		
	Gonorrhea			Screen		
	Syphilis			Screen		
	HIV/AIDS			Screen		
	Hepatitis C			Screen		
	Diabetes		Screen			
Counseling	Condoms with practice	X		X		
	STD/HIV			X		
	Pregnancy prevention	X				
	Preconception health		X			
	Sexuality & relationships					X
	Sexual dysfunction					X
	Infertility				X	

Summary

- Males have substantial SRH & family planning needs & deserve to receive quality care
- QFP & MTC use an evidence-informed approach to make recommendations for delivery of clinical preventive SRH services to males
- Strength of guidance is its integrated approach for addressing men's SRH



Limitations

- During process of synthesizing recommendations we identified a number of gaps in clinical guidance on males' SRH & a dearth of research in this area
- Although some recommendations by expert opinion may be on lower end of evidence ladder*, they can have merit & be useful in context when
  - High-quality evidence is lacking &
  - Procedures used to develop them are explicit & transparent

* Atkins et al. BMC Health Serv Res 2004;4(1):38.

Conclusion

- Guidance by *QFP* & MTC defines for 1st time quality of SRH care to deliver to males
- These guidelines can
  - Serve as foundation for national standards to deliver SRH care to males in the US, &
  - Assist healthcare providers & programs to provide most effective & efficient services while also improving males' access to SRH care

Resources

Male Training Center
http://www.maletrainingcenter.org/

CDC/OPA Providing Quality Family Planning Services
http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf

CDC STD Treatment Guidelines 2010
cdc.gov/std/treatment/2010/default.htm
For iPad, iPhone & iPod Touch
cdc.gov/std/2010-ebook.htm

CDC HIV Prevention & Treatment Guidelines 2013
cdc.gov/hiv/living/treatment/guidelines.htm

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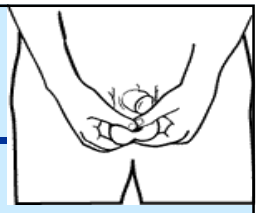
AND input from members of Title X Expert Work Group & the MTC's Advisory Committee

2011 USPSTF statement



Screening for testicular cancer

D Recommendation = against routine screening for testicular cancer in asymptomatic males

Additional note

"Clinicians should be aware that patients who present with symptoms of testicular cancer are frequently diagnosed as having epididymitis, testicular trauma, hydrocele or other benign disorders"

USPSTF statement rationale

1. No new evidence found that
   - Screening with clinical examination OR
   - Testicular self-examination

   is effective in reducing mortality from testicular cancer
2. In screening absence, current treatments provide favorable health outcomes
3. Harm of screening exceed potential benefits, given
   - Low prevalence of testicular cancer
   - Limited accuracy of screening tests
   - No evidence for incremental benefits of screening
4. However…
   - No study has ever assessed harms associated with testicular cancer screening
   - Individuals at increased risk may not know they are (e.g., correction for cryptorchidism)

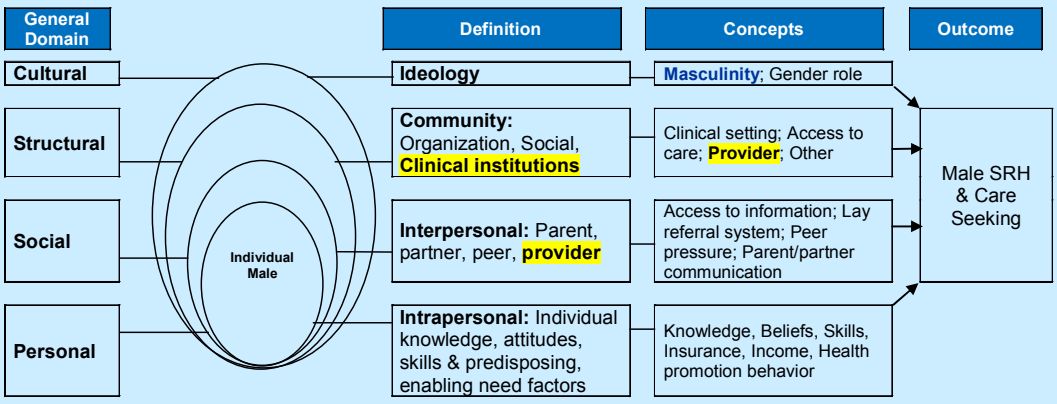
Exam: External genital

2012 SAHM Position Statement: The Male Genital Exam

Recommend perform genital exam among adolescents to

1. Document **Sexual Maturity Rating** (SMR) & progress in development
   - Document SMR separately for Hair & Genitals
2. Screen for **visual STI symptoms** (warts, HSV lesions)
3. Screen for **genetic diseases** (Klinefelter's; 21-CAH)
4. Identify **structural anomalies** (varicocele, spermatocele, hydrocele, meatal abnormalities (hypospadias), signs of testicular trauma)
5. Issues related to an **uncircumcised penis** (phimosis/ paraphimosis; Hygiene issues)
6. **Hair/skin** issues (folliculitis/ jock itch)
7. **Absent testes** (cryptorchidism)
8. **Testicular atrophy** (central cause; steroid/MJ use)
9. Reassure **normal variations** (penile pearly papules, sebaceous cyst)
10. Help patient gain a better understanding of his body

Socio-Ecological Framework for Male SRH & Care Seeking



Barriers to SRH care delivery
Influences at multiple levels

Individual patient level
- Lack of public health messages that sexually active males should seek care in general or for SRH
- Access to & use of healthcare

Provider level
- Gender, specialty, year of graduation
- Training, self-efficacy in care delivery (comfort taking sexual history)

Clinic setting level
- Services not designed to meet males' SRH needs
- Time, competing demands, financial incentives, compensation
- Decision-support tools (reminder systems) & access to internal (e.g. health educators) or external (e.g. urology) referral resources

System level (HEDIS measures)
- **No one professional organization makes recommendations for male SRH care across lifespan**
- But, guidelines alone do not ensure provider compliance*

* Solberg LI, et al. Jt Comm J Qual Improv. 2000; 26:171-88

Minor Consent in Maryland

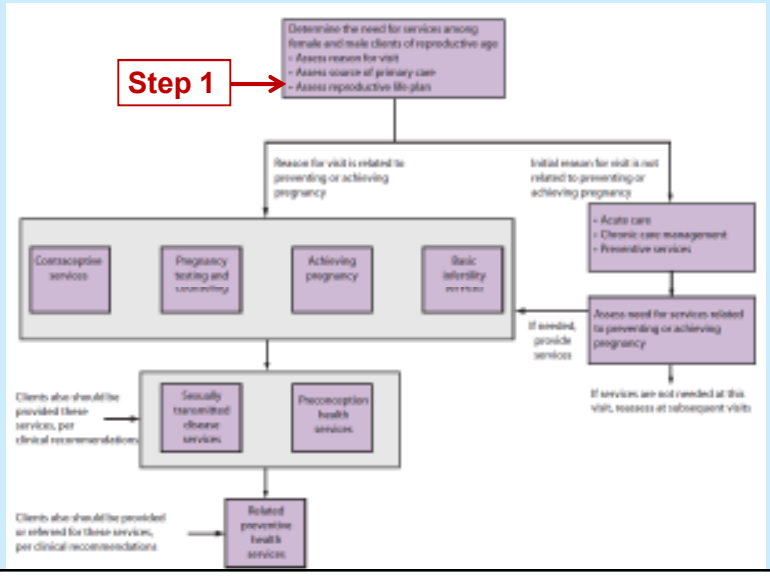
Minors can seek following types of care without needing parental permission:

1. Sexual & reproductive health
   - STD/HIV-related care
   - Contraception (except sterilization)
   - Pregnancy-related care
   - *Abortion (requires parental signature)*
2. Substance abuse
3. Alleged rape/sexual offence
4. Urgent problem
5. Mental health (≥16 only)
6. If minor is married; a parent; or living separate/apart from parent(s)/guardians & self-supporting, they can consent for all care

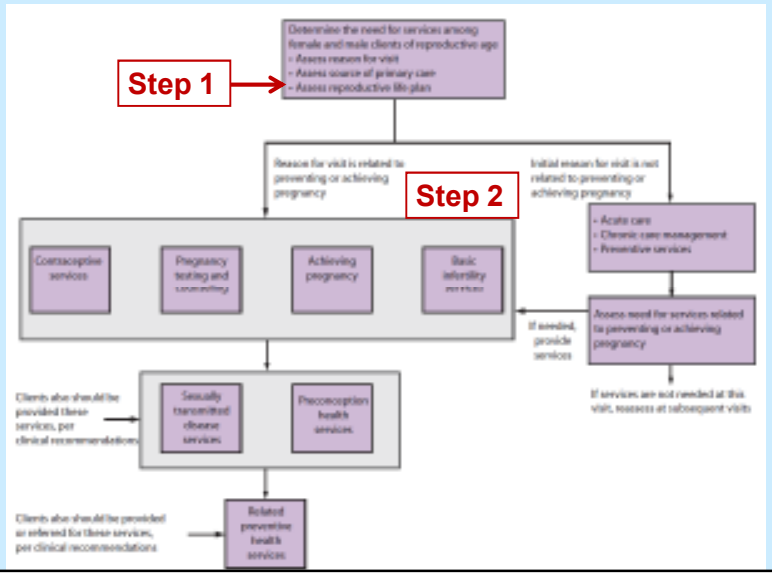
History components

Content	**Standard medical history**
Questions	• Assess for pregnancy & father history as part of standard medical history
Who/When	• All ages / Each encounter
Source	• CDC Preconception care

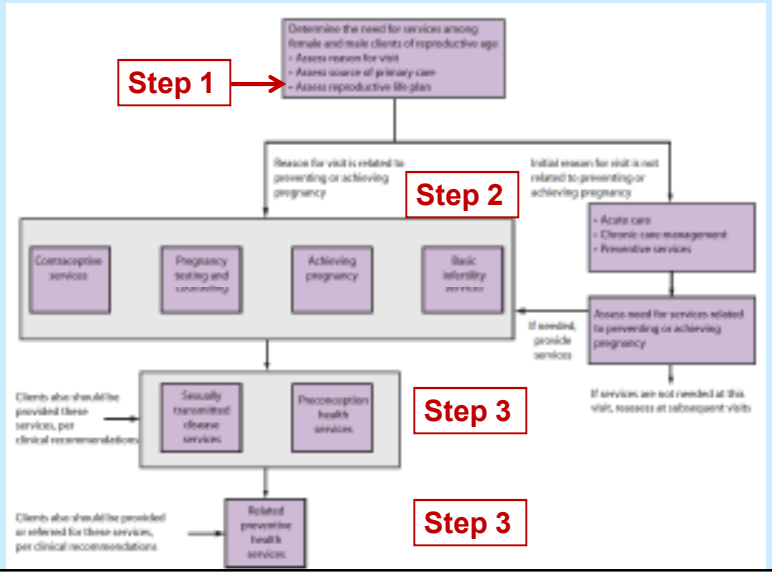
Clinical pathway for providing SRH services to males



Clinical pathway for providing SRH services to males



QFP clinical pathway for providing SRH services



History: Intimate partner violence

Example evidence-based screen

- HITS... How often does your partner…
  - **H** Physically **HURT** you?
  - **I** **INSULT** or talk down to you?
  - **T** **THREATEN** you with harm?
  - **S** **SCREAM** or curse at you?

Score each item using 1 to 5 on a Likert scale as follows: never (1); rarely (2); sometimes (3); fairly often (4); frequently (5).

Scores range from 4 to 20. Score >10 considered positive for partner violence. Provide counseling & referral as appropriate.

Rabin et al. Intimate partner violence screening tools: a systematic review. Am J Prev Med 2009 May;36(5):439-445 e434.

History: Alcohol & other drug use

CRAFFT is example evidence-based screen for adolescents through age 21

During past 12 months, did you:

1. Drink any alcohol (more than few sips)? (Don't count sips taken during family or religious event)
2. Smoke any marijuana or hashish?
3. Use anything else to get high? (e.g. illegal drugs, OTC/prescription drugs, things you sniff/"huff")

If answer is "**No**" to all questions, ask only CAR question below.
If answer is "**Yes**" to any of 3 questions, ask all questions below.

C Have you ever ridden in **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
R Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?
A Do you ever use alcohol/drugs while you are by yourself, **ALONE**?
F Do you ever **FORGET** things you did while using alcohol or drugs?
F Do your family or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?
T Have you gotten into **TROUBLE** while you were using alcohol or drugs?

Probability of abuse/dependence increases with increasing yes answers to above questions.

- Other validated screening tool includes the ASSIST

Knight et al. A new brief screen for adolescent substance abuse. Arch Pediatr Adolesc Med 1999;153(6):591-596.

History: Tobacco use

The "5 A's" approach:

ASK "Do you smoke cigarettes or use tobacco?"

ADVISE "Quitting smoking/tobacco use is most important thing you can do to protect your health now & in future. Clinic staff & I will help you."

ASSESS "Are you willing to make quit attempt in next 30 days?"

ASSIST
1. Help develop quit plan (e.g., set quit date in next 2 weeks, tell friends & family quit intent & request support, anticipate challenges to quit, & remove nicotine products)
2. Give key advice (e.g., total abstinence, review past quit experiences if any & factors that hindered past attempts)
3. Consider nicotine replacement therapy or refer

ARRANGE Refer to intensive services (help lines, websites, treatment programs & follow-up to review progress.

Epps et al. A physician's guide to preventing tobacco use during childhood and adolescence. Rockville, MD: National Cancer Institute; 1990.

History: Depression

Staff-assisted care support defined

- Assist primary care clinician by providing some direct depression care
  - Care support or coordination, case management or mental health treatment
  - For example, screening nurse who advises clinician of positive screen & provides protocol facilitating referral to therapy

Example screening approach

- Screening in primary care with 2 questions*
  1. During past month, have you often been bothered by feeling down, depressed, or hopeless?
  2. During past month, have you often been bothered by little interest or pleasure in doing things?
- Other validated screening tools:
  - PHQ9
  - CES-D

*Arroll et al. Screening for depression in primary care with two verbally asked questions: cross sectional study. BMJ. 2003; 15; 327(7424):1144-1146.

History: Suicide

Things to watch for when assessing potential risk

P.L.A.I.D. P.A.L.S.

Plan	Do they have one?
Lethality	Is it lethal? Can they die?
Availability	Do they have the means to carry it out?
Illness	Do they have a mental or physical illness?
Depression	Chronic or specific incident(s)?
Previous attempt	How many? How recent?
Alone	Are they alone? Do they have a support system? Partner? Are they alone right now?
Loss	Have they suffered a loss? Death, job, relationship, self esteem?
Substance abuse	Drugs, alcohol, medicine? Current, chronic?

San Francisco Suicide Prevention. P.L.A.I.D.P.A.L.S. 2006 [cited June 2012]; Available from: http://www.sfsuicide.org/prevention-strategies/warning-signs/p-l-a-i-d-p-a-l-s/

Physical exam components

Content — **External genital / perianal**

Exam
- Perform as part of evaluation for male infertility (older male)

Who/When
- Based on need

Source
- American Urological Association

Counseling: Infertility

- Early evaluation if known male or female infertility risk factor exists or if man questions his fertility potential:
  - Couple attempting to conceive should have evaluation for infertility if pregnancy fails to occur within 1 year of regular unprotected sex
  - An evaluation should be done before 1 year if
    1. Male infertility risk factors such as history of bilateral cryptorchidism are known to be present
    2. Female infertility risk factors (e.g., advanced female age (>35 years)), are suspected, or
    3. Couple questions male partner's fertility potential
  - Men who question their fertility status despite absence of current partner

Counseling: Infertility cont.

- Counseling & referral provided during clinical visit should be driven by information elicited from client during initial infertility history & physical exam (as described above)
- Referral may be needed for further evaluation (for semen analysis (2 specimens), endocrine evaluation for testosterone & FSH levels, or post-ejaculate urinalysis (when ejaculate volume is <1mL)
- For patients who fall under prior definition, but are concerned about infertility & no apparent cause, provide education about how to maximize fertility

Counseling: Sexuality

Example tool: Have you ever…

…been hit, slapped or physically hurt because of your LGBT identity?
…experienced verbal harassment or name-calling because of your LGBT identity?
…been excluded from family events or activities because of your LGBT identity?
…been blocked access to LGBT friends, events, & resources?
…been blamed when you have been discriminated against because of your LGBT identity?
…been pressured to be more (or less) masculine or feminine?
…been told that God will punish you because you are gay?
…been told your family is ashamed of you or that how you look or act will shame the family?
…been told to keep you LGBT identity a secret in the family & not letting you talk about your identity with others?

Ryan C. Helping families with lesbian, gay, bisexual & transgender children. San Francisco, CA: San Francisco State University. 2009; familyproject.sfsu.edu.

Counseling: Relationships

Example tool: Friend, girlfriend, or boyfriend – all deserve healthy relationships.

- **Respect.** Are you accepted for who you are? No one should pressure you into continued doing things you are not comfortable with such as drinking, drugs, or unwanted physical contact.
- **Safety.** Do you feel emotionally & physically safe? You should feel comfortable being you without fear of being put down. Being hurt or feeling pressured is definitely not safe!
- **Support.** Do your friends care for you & want what is best for you? Your friends should understand if you can't hang out because you have to study or if you have plans with other friends.
- **Individuality.** Do you pretend to like something you don't or be someone you aren't? Be yourself; after all, being an individual is what makes you, you!
- **Equality.** Do you have an equal say in relationships & put equal effort into the relationship? From activities you do together to friends you hang out with, you should have equal say in choices made in relationships.
- **Acceptance.** Do your friends or girlfriend or boyfriend accept you for who you really are? You shouldn't have to change who you are, or compromise your beliefs to make someone like you.
- **Honesty & Trust.** Are you always honest? Honesty builds trust. You can't have a healthy relationship without trust! If you have ever caught your friend or boyfriend or girlfriend in a huge lie, you know that it takes time to rebuild trust.
- **Communication.** Do you talk face to face (nt jst txt!) about your feelings? Listen to one another & hear each other out. Text or Facebook messages should be respectful, not mean or inappropriate.

Building healthy teen relationships Boise, ID: Idaho Coalition Against Sexual and Domestic Violence; http://idvsa.org/; and http://lovewhatsreal.com/ Accessed 9/10/12.

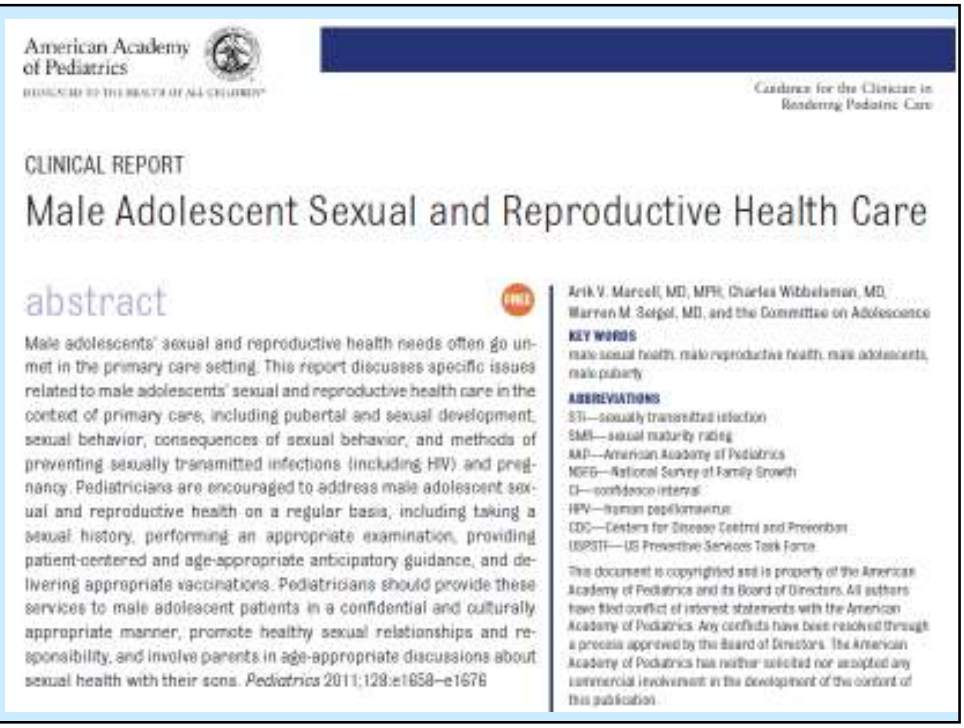
Counseling: Relationships

Signs of unhealthy relationships

- Texts you all the time to find out where you are, who you're with, or what you're doing
- Has to be with you all the time
- Doesn't listen to your opinion
- Makes all the decisions in the relationship
- Makes fun of you or puts you down when you are alone or with friends
- Does things to upset you or make you cry
- Wants you to change who you are
- Asks you to give up activities you enjoy
- Won't let you hang with your friends
- Pressures you to do things you are not comfortable with
- Makes you feel guilty, "gets back at you" or punishes you for things you do for yourself
- Threatens to hurt you or him/herself as a way to control you

Building healthy teen relationships Boise, ID: Idaho Coalition Against Sexual and Domestic Violence; http://idvsa.org/; and http://lovewhatsreal.com/ Accessed 9/10/12.

2011



American Academy of Pediatrics

Guidance for the Clinician in Rendering Pediatric Care

CLINICAL REPORT

Male Adolescent Sexual and Reproductive Health Care

abstract

Male adolescents' sexual and reproductive health needs often go unmet in the primary care setting. This report discusses specific issues related to male adolescents' sexual and reproductive health care in the context of primary care, including pubertal and sexual development, sexual behavior, consequences of sexual behavior, and methods of preventing sexually transmitted infections (including HIV) and pregnancy. Pediatricians are encouraged to address male adolescent sexual and reproductive health on a regular basis, including taking a sexual history, performing an appropriate examination, providing patient-centered and age-appropriate anticipatory guidance, and delivering appropriate vaccinations. Pediatricians should provide these services to male adolescent patients in a confidential and culturally appropriate manner, promote healthy sexual relationships and responsibility, and involve parents in age-appropriate discussions about sexual health with their sons. *Pediatrics* 2011;128:e1658–e1676

Arik V. Marcell, MD, MPH, Charles Wibbelsman, MD, Warren M. Seigel, MD, and the Committee on Adolescence

KEY WORDS

male sexual health, male reproductive health, male adolescents, male puberty

ABBREVIATIONS

STI—sexually transmitted infection
SMR—sexual maturity rating
AAP—American Academy of Pediatrics
NSFG—National Survey of Family Growth
CI—confidence interval
HPV—human papillomavirus
CDC—Centers for Disease Control and Prevention
USPSTF—US Preventive Services Task Force

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Position Paper

The Male Genital Examination: A Position Paper of the Society for Adolescent Health and Medicine

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